Medicaid Eligibility Reporting Period and Calculation options-source: FAQ10362/FAQ299

Definition of reporting period:	Any consecutive 90 days from the previous calendar year (2013) or a consecutive 90 day period prior to the submission of application for the program year you are applying for. **Note:** The 90 day period does not have to begin on the first of a month. The Medicaid eligibility reporting period does not have to match the reporting period for an individual providers meaningful use reporting period. They are two different reporting periods.
Individual provider enouncounters:	One provider's total patient encounters for a 90 day period divided by the # of Medicaid patients from that total. If an individual works in a practice setting and uses their individual encounter numbers for their Medicaid eligibility calculation then all providers from that practice must use the individual method if they are also applying for the Medicaid incentive program.
Practice/Group level encounters:	**To group encounter numbers together for a practice or multiple practices the three conditions below must be met:**

(1) The clinic or group practice(s) patient volume is appropriate as a patient volume methodology calculation for the EP; and

(2) there is an auditable data source to support the clinic's patient volume determination; and

(3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

Note from MaineCare HIT: You may use your billing/claims system as well as other sources to acurately calculate your percentage. You will need to tell us: 1) The source of your information; 2) which consecutive 90 days you chose; 3) whether you chose to determine encounters based on the individual professional or at the practice level (all of the eligible professionals in the practice). Note: If you are a professional practicing in a Federally Qualified Health Center or Rural Health Center, use the Uniform Data Set (UDS) report for the previous calendar year.

In order to provide examples of how to calculate, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

CLINIC A (with a fictional EP and provider type)

EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
EP #3 (physician): individually had 10% Medicaid encounters (30/300)
EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

Purpose of rules:
The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

Provider working at multiple sites:
Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP #4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.